FAMILY RECOVERY: THE FUTURE FOR CHEMICALLY DEPENDANT CHILDREN

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by
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ABSTRACT

Family Recovery: The Future for Chemically Dependent Children

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The intent of the project is to address the need for family involvement in the recovery process of adolescent addicts. The problem is that while the concept of family involvement in the treatment and recovery of chemically dependent children is considered to be essential to their success, few treatment programs effectively incorporate families into that process.

Experts in the field have long extolled the need for complete family involvement in treatment, citing the failure of individual treatment and the success of new modalities involving the knowledge of the systemic nature of addiction. Treatment focusing on adolescents is in particular need of a new emphasis on family recovery, as the individual is likely to return to the former addiction-creating home environment.

The treatment industry is currently in a state of change, and possibly crisis, brought on as the result of restrictions initiated by the insurance industry and the federal government. The result has been the closing of many treatment programs and the curtailing of long periods of inpatient treatment. These influences, as well as public

opinion, work toward the continuance of an individualistic focus in treatment.

The project examines several models for recovery, including Terence Gorski's developmental model of relapse and recovery, and the Anchor Hospital multimode program. Both stress the need for complete family involvement from the beginning of treatment and through the long term phases of recovery.

Another model, the P.A.R.T.S. (Parents and Adolescents Recovering Together Successfully) program in San Diego, California, is also reviewed. This program was developed by parents who saw the need to be more closely involved in their child's recovery, and grew as a grassroots response. The program, as it stands today, operates within the framework of long-term recovery, and promotes family participation in its own process. It is intended to be adaptable as an adjunct to any treatment program, and does not endorse any particular format.

The project demonstrates the real lack of family-based recovery ideals within the industry, and suggests that the future of recovery is in the family, particularly for adolescent addicts.

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Many tears and many years have gone into the completion of this project. I would not have finished it without the encouragement and support of the P.A.R.T.S. (Parents and Adolescents Recovering Together Successfully) family and the many dear friends I have there. We have struggled together over the years to comprehend the power and destruction of addiction, yet we have also rejoiced together in recovery. Today there are many young adults who live life in wholeness as a result of our fellowship. This is for Kristie, Allie, Chuck, Jimmy, Gail, Ben, Alisa, and Drew, whose aliveness is a joy to those of us who have witnessed their recovery.

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CHAPTER 1

Introduction

Problem

The intent of this project is to address the need for family involvement in the recovery process of adolescent addicts. The problem is that while the concept of family involvement in the treatment and recovery of chemically dependent children is considered to be essential to their success, few treatment programs effectively incorporate families into that process.

Treatment specialists recognize the gravity of the family's influence on an individual's recovery from addiction. But it is difficult to interpret that into effective programs when families bring their sick members, particularly children, to these specialists, and are unwilling or slow to accept that they might need as much healing as the individual with the addiction. The treatment facility is often forced to accept a patient under less than ideal conditions.

Purpose

The primary target of this project is the family, with the goal being the successful treatment and recovery of

young people suffering from dependency to illegal drugs and alcohol. Although treatment programs no longer approach treatment with the sole focus on the addict or alcoholic, and they are aware that an individual's family is of primary importance in the recovery process, most programs do not effectively involve families in recovery.

In the last decade, leading experts in the field of addiction studies and treatment began recognizing that the majority of specialized programs designed to treat chemically dependent individuals were poor at best, and that if any program were to become effective, it would need to incorporate the patient's family into the treatment process.[1] Yet, as already mentioned, there has been little realistic movement in that direction. Nearly everyone involved in addiction treatment recognizes the need for family members to become involved with a twelve step program such as Alcoholics Anonymous, Alanon, Coda (Codependents Anonymous), or ACA (Adult Children of Alcoholics). In many cases the recovery of the individual is dependent upon changes in family functioning and interaction which could be encouraged or enhanced by family participation in treatment. These changes could be considered the recovery of the family from its addictive influence on the adolescent. In many instances, if the family makes no movement toward changing,

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[1] Sharon Wegscheider, Another Chance: Hope and Health for the Alcoholic Family (Palo Alto, Calif.: Science and Behavior Books, 1981), 23.

the individual is reintroduced into the same environment which encouraged or supported addiction.

When treatment focuses on the adolescent addict or alcoholic, the importance of involving the family is even more obvious. Yet, aside from the growing number of experts who advocate this, adolescent chemical dependency programs still suffer from the same lack of family involvement which adult programs experience.

Further complications exist. Over the last several years major insurance carriers which funded addiction treatment programs began reducing their coverages. This has been particularly true of the large employee group carriers and HMO's. Although primary services for psychiatric emergencies are still covered, the majority of carriers will no longer fund in-patient or residential treatment solely for chemical dependency or abuse.

Thesis and Major Ideas

The intent of this project is to demonstrate that an organized treatment program, which includes close family participation in both the recovery process of the individual and in its own recovery as a functional whole, is essential in the recovery of chemically dependent adolescents. A model will be suggested which can support continuing recovery in a nurturing and supportive environment.

Most people are aware of the tremendous impact of illegal drugs and narcotics. There has been such an

increase of use and addiction that the problem has become epidemic. Roughly one out of every ten Americans suffers from addiction, and nearly one out of every six teenagers is addicted.[2] As each year passes, the age of onset for chemical use and dependency (both drugs and alcohol) becomes younger. Treatment programs and hospitals have admitted children as young as eight-years old with a diagnosed drug or alcohol problem.

The general response in our country toward addiction and alcoholism, though, is dominated by our attitudes regarding individualism. While we are a society that has taken great care to maintain the pioneering concept of the rugged individualist, we often fail to acknowledge the effect of others on individual success or failure. When applied to the general problem of alcoholism and addiction, this individualism becomes individual blame or guilt. Public interest in drug use, for instance, is often isolated to the illegal drug trade, and focused on identifying and prosecuting the individuals responsible for it.

The treatment community, on the other hand, has little to do with the issue of where illicit chemicals come from. Instead, it focuses on treatment needs: that individuals and families take responsibility for their recovery. Alcoholics

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[2] Geraldine Youche and Judith S. Seicas, "Drinking, Drugs, and Children," Parents Magazine, March 1989, 142.

Anonymous and Alanon have had a large influence in this area. The impact of their influence has been the general acceptance of two operating principles within the recovery community: the general acceptance of the disease model of addiction, and the necessity of involving the addict's family in its own program of recovery.

The necessity of family recovery is even more acute when the addict is a child. The implications are threatening to families which have likely been closed to outside scrutiny, and the potential for family disintegration is extreme. Families who submit themselves for therapy in the hope of achieving a successful recovery for their sick member must open the doors to their closely guarded family secrets as they find themselves forced to accept the frightening and threatening process that is involved in recovery. Hopefully, they will also discover that this is necessary in order to achieve healing.

All families tend to resist intrusion into their privacy, and carefully guard their secrets. But families with addicted or alcoholic children must ultimately face the threat of exposure. They must go through the fire in order to reach the other side, there is no path around it. In a sense, the process involves the death and rebirth of the family. The successful recovery of an addicted or alcoholic child is greatly dependent on the recovery of his or her primary family. Addicted children are, as this project will

demonstrate, symptomatic of a larger family problem.

Definitions

Addiction, alcoholism, and chemical dependency are the core problem with which this project will deal. In order to meet the criteria for psychoactive substance dependency in DSM-III-R, individuals must display characteristics of tolerance and withdrawal in regard to their identified drug of choice.[3] Psychoactive substances include alcohol, most narcotics, and many prescription drugs: in short, these include any substance which alters mood, behavior, or perception, or any combination of these, under certain circumstances. As individuals progress in usage they develop a marked need for greater amounts of a particular substance, hence tolerance. They further will display characteristic symptoms of withdrawal if they cease or are forced to cease use. For the purpose of this project, dependency and addiction will be considered synonymous, and the term addict will apply to dependency on any substance, including alcohol.

Though there are varying opinions regarding the addictive effects of different psychoactive substances, including alcohol, narcotics, and prescription drugs, this project will assume that all commonly used drugs of choice are addictive. It is also important to remember that

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[3] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 3rd ed., rev. (Washington, D.C.: APA, 1988), 166.

adolescents generally have not had the time to establish the long-standing patterns of addiction which are evident in adult addicts, nor have they developed the more sophisticated networks of drug subculture connections. But peer group influence is strong among adolescents, and may have nearly the same power over the individual which adult systems display.

Recovery is the vision held up in this project. Recovery, in the general medical sense, is commonly understood to include some aspect of an individual's return to pre-illness status. In the case of alcoholism and addiction, recovery is considered to include abstinence from addictive chemicals. This is consistent with the principles of Alcoholics Anonymous, contending that individuals, once they have declared themselves alcoholic, can never return to any pattern of use.

Many styles exist for treating substance abuse problems. These include Alcoholics Anonymous, Narcotics Anonymous, Alanon, clinical treatment facilities which offer both inpatient and outpatient programs, and various civic and government sponsored programs. For this project, treatment will be used to indicate the period involving professional intervention, which would usually include inpatient treatment and aftercare services.

Within the framework of this project, therapy will include those elements of treatment which involve services

of a licensed professional such as a psychologist, psychiatrist, or a clinical social worker. These services are normally provided in the course of individual or family counseling sessions, but may also include group sessions.

Work Previously Done in the Field

A great deal of current research and theory in the area of adolescent recovery from chemical dependency indicates the importance of family therapy, and most researchers propose models for implementation of their individual visions. Some of the work reviewed for this project focuses on specific elements of the treatment process, including intervention, assessment, clinical treatment, and aftercare, with special attention being given to those works which deals with family involvement in recovery.

George Beschner, of the National Institute on Drug Abuse, has stated that in 1984 more than 65,000 young people between the ages of 12 and 19 years entered drug and alcohol treatment facilities. He indicated that treatment practices at that time were relatively ineffective, concluding that treatment programs should involve parents from the very beginning and should include aftercare and more rigorous evaluation practices.[4] In the last five years most programs of intervention and treatment have increasingly stressed

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[4] George Beschner, "Treatment for Childhood Chemical Abuse, "Journal of Children in Contemporary Society 18 (Fall-Winter 1985): 248.

family involvement in the process, but the actual level of family involvement across the board is unknown, and the results are limited.

A large number of journal articles can be found in the general category of adolescent chemical dependency and, not surprisingly, these articles indicate the need for family involvement in an individual's recovery from addiction. In addition, many books are oriented specifically around the role of family in both addiction and recovery. In their book, The Family Therapy of Drug Abuse and Addiction, authors M. Duncan Stanton and Thomas C. Todd advocate that the family system acts as a strong determinant in both an individual's addiction and recovery. They propose several levels of family involvement in treatment as the result of their extensive clinical observations.[5] The majority of their research involves adult addiction and treatment, although they pay special care to identifying adolescent treatment issues. They stress the importance of treating the family as an addictive unit, although only one member may be the identified addict.[6]

Stanton and Todd's book contains a chapter on adolescent drug abusers. It addresses the dynamics of

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[5] M. Duncan Stanton, Thomas C. Todd, and Associates, The Family Therapy of Drug Abuse and Addiction (New York: Guilford, 1982), 335.

[6] Stanton and Todd, 22.

crisis oriented families and family resistance to treatment, as well as the contrast between adult and adolescent issues. One weakness is that the book is approximately ten years old, and some of the identified differences between adolescents and adults in treatment have changed since the 1982 publication date. Whereas it identifies adults as having a stronger identification with a drug subculture, or peer group, which may have been true ten years ago, today's adolescents have an equally strong drug subculture. Also, adolescent drug abusers were seen as less likely to be deeply involved in criminal activity than their older counterparts. Today, that gap has also narrowed.[7]

Another Chance, Hope and Health for the Alcoholic Family, by Sharon Wegscheider, is now considered a watershed book regarding the interaction of family members in an alcoholic family.[8] Although she does not stress a systems approach to families at the outset, her description of family interrelatedness is supported in systems theory, and she identifies the family as a system in later chapters. In chapters 12 through 14 she outlines a program of recovery based on her personal experience and her knowledge of programs current at the time of writing. The obvious missing element, in retrospect, is that of an active working

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[7] Stanton and Todd, 337.

[8] Wegscheider.

model which supports her work. Although many programs have attempted to act on this or similar plans, they have generally fallen short of creating the environment which stimulates the kind of change she envisions.

A recent entry into the field of codependency issues is Sara Hines Martin's Healing for Adult Children of Alcoholics[9]. Her work circumscribes the elements of alcoholic, dysfunctional families, and describes the relationship dynamics within alcoholic homes. Although she primarily addresses children of alcoholics, the family dynamics she describes are very similar to those in homes with addicted children.

Several books in the field of pastoral care to families will be utilized. These include Herbert Anderson's The Family and Pastoral Care, and Jim Larson's A Church Guide for Strengthening Families. Anderson describes the healthy family as an interdependent unit within the larger social system, and he devotes the majority of his writing to developing his idea of family health.[10] Larson, on the other hand, orients his book toward developing a strategy of family ministry which incorporates systems theory as its foundation. This strategy includes models for marriage enrichment, parent education, and family enrichment programs

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[9] Sarah Hines Martin, Healing for Adult Children of Alcoholics (Nashville: Broadman, 1988.)

[10] Herbert Anderson, The Family and Pastoral Care (Philadelphia: Fortress, 1984): 50.

and groups.[11]

Another work, Family Therapy in Pastoral Ministry, by J. C. Wynn, offers an excellent pastoral perspective into family dynamics, again from a systems point of view. Wynn approaches the task of family ministry from the perspective of a therapist, and provides a useable framework for a counseling ministry within the church.[12]

Other major contributors in the field of recovery or codependent recovery include Claudia Black and Melody Beattie, well known not only for their books on codependency but also for worldwide lectures and workshops, and Terence Gorski, who developed one of the most widely adapted models for recovery programs. Gorski is also a popular lecturer in the recovery field. Their input has directly impacted the majority of writing being done today, and it offers an important foundation for this project.

Scope and Limitation of Project

The purpose of this project is to develop a strategy of family ministry to families with chemically dependent children. The ultimate objective is to lay the groundwork for a program which can be adapted as a church ministry that comprehends and addresses the dynamics of addictive families. The method used in this project is to examine the

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[11] Jim Larson, A Church Guide for Strengthening Families (Minneapolis: Augsburg, 1984), 47.

[12] J. C. Wynn, Family Therapy in Pastoral Ministry (San Francisco: Harper and Row, 1982.)

current status of addiction treatment, and to assess the strengths and weaknesses of family programs in that field. Most treatment facilities and programs desire to incorporate families into the overall treatment regimen, and some of these claim at least partial success. Yet, in the face of overwhelming support for a family centered therapy, few programs manage successfully to involve families in recovery from addiction. Further, many professional alcohol and drug treatment centers are closing due to recent financial constraints from both the insurance industry and the federal government. This suggests even more opportunity and need for ministry.

Although the purpose here is not to readdress the general problem of drugs and alcohol in our society, some of the issues discussed will approach the larger problem. At the very core of the recovery crisis are the issues which allow members of our society, and particularly children, to become addicts today. Also, this project will not attempt to argue for or against the various theoretical models which attempt to explain alcoholism and addiction, such as the disease, cultural, behavioral, or learning models. The disease model is the most widely accepted within the treatment and recovery program, yet the others have their utility in developing family treatment strategies.

Because this is a pastoral ministry project, one of the goals will be to demonstrate why and how the church should

be involved, and where the concept of pastoral care can be applied.

Procedure for Integration

In order to provide support for the thesis it will be necessary to pursue some historical development within the treatment industry. Chapter 2 details the current state of affairs in the treatment industry, including the impact of changes in the insurance industry and the potential effect of government programs. Chapters 3 and 4 address addiction from a systems perspective, focusing on dysfunctional family styles which encourage and support addiction and alcoholism.

The project also suggests a model for family recovery in Chapter 5. For this purpose the project will borrow from personal experiences with the REACH adolescent chemical dependency program of the Harborview Hospital, San Diego, California, and the P.A.R.T.S. (Parents and Adolescents Recovering Together Successfully) organization which was founded by parents who felt the need to become more closely involved with their childrens' recovery. In my experience these two programs, which worked closely together, offered one of the best possible environments for recovery.

The overall subject is the therapeutic process of recovery from addiction. Work in this field has typically been accomplished by individuals or professionals not directly associated with a religious organization, although there has been some involvement by individuals practicing

the discipline of pastoral counseling. The intent is to demonstrate both a need and a method by which the church can become more involved in caring for addicts and alcoholics.

Hopefully, this project will broaden the perspective of the average pastor, who is limited by the demands and time constraints of the parish, but who needs to be able to interact with the increasingly complex issues of our culture, one of the more challenging being drug and alcohol addiction.

At the core of the family healing process, and something which will hopefully be validated in this project, is the confrontation and disclosure of family secrets and sickness, the crisis which these disclosures precipitate, and the inevitability of crisis in the recovery and healing process. From a Christian perspective, the family healing process bears a striking resemblance to the confession and reconciliation of atonement. Pastors, when properly equipped, could become the most effective facilitators of healing, considering the fact that they are still perceived as specialists in atonement.

Although some churches conduct specialized ministries with recovering addicts and alcoholics, the church in general has made no large effort to provide for the recovery of the swelling tide of addicted adults and young people. The church and addicts are two highly individualized communities, and they seldom come together, at least in

public.

As new circumstances unfold, shedding new light on the prospects of treatment, churches might find themselves the most likely candidates for offering recovery programs. Even if events do not dictate this, Christianity is already slighting one of the most needful areas where genuine ministry could be provided. We who are pastors should pay careful, caring attention to the needs of families with addicted members.

CHAPTER 2

Addiction: The Large Picture is Out of Focus

How have individual lives been impacted by addiction? Have some had it hit close to home and directly effect the quality of their lives, has it possibly affected the lives of their other acquaintances, or has its impact been mostly indirect and by way of the local news? Whatever the source, the addictive use of chemicals has had its effect on every member of contemporary society. If people have experienced addiction in their families, they may have suffered the pain of watching their lives disintegrate as they struggled for answers to imponderable questions. Some may be among the more fortunate who have only witnessed the impact of addiction from a comfortable distance, and only experienced the cost in the form of new tax appropriations targeting the illegal drug industry, or escalating insurance premiums to support an increased need for the care and supervision of recovering individuals.

Individual attitudes regarding the cause and cure of addiction may also be subject to the effect it has had on them. To some, addicts should be considered criminals and treated so, while to others they are sick and misunderstood,

needing care and professional treatment. Yet the general interpretation of society is probably influenced by something other than the concrete impact of addiction on individual lives.

In this age of the media event, society is bombarded with interpretations blaming addiction on drug traffickers, and describing addicts as part of that network. After all, major drug interdictions and arrests make much more interesting news than the work being conducted in treatment programs. When the President of the United States announced his "War on Drugs" in 1989, he identified participants in the illegal drug market as his primary targets, and he gave a much smaller role to the needs in the field of treatment and recovery.[1] Law enforcement agencies across the country, and even specialized agencies such as the Immigration and Naturalization Services and the Border Patrol, have adjusted their budgets to reflect a heavy emphasis on intercepting drug traffic and importing.

Hollywood, which would have suffered a serious shortfall in subject matter if it were not for illegal drug trade, has managed to interpret all of this business into dramatic and action-filled entertainment. In a recent article, film critic C. C. Wilson contrasted the few movies which address the struggle of addicts and alcoholics with

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[1] Jeffrey T. Kramer, "Demand Reduction: The Treatment Side of the War on Drugs," Professional Counselor 4, no. 5 (March-April 1990): 54.

the many more films that deal peripherally with addiction. In addition to the standard fare of action films pitting good against bad in settings involving the drug trade, there have been some recent films detailing the plight of alcoholics and addicts. But overall, films and television tend to use addiction as a backdrop for violent, action-oriented plots.[2] The issue, as he presents it, is one of excitement and entertainment: "Feature films tend toward simplistic, extremist notions of human motivation."[3] He does offer some hope, though, that the film industry might begin to air more realistic portrayals of addiction and alcoholism:

> But the film industry does mirror public awareness. As understanding of addiction moves into the mainstream, movies might yet begin to reflect the complexity that characterizes real-life addiction."[4]

In this introduction, the intent is not to level a criticism at the media or contemporary forms of entertainment, but to offer the possibility that attitudes are not always the result of direct impact. Individuals are influenced indirectly by the attitudes of others, and particularly by attitudes conveyed within the media and entertainment industries. The oversimplified characterizations of addicts in films convey a lasting

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[2] C. C. Wilson, "The Movies and Addiction," Sober Times 6, no. 2 (February 1992): 25.

[3] Wilson, 25.

[4] Wilson, 25.

imagery which is bound to effect individual opinions of addiction when it is encountered in real life. This is particularly true if there is no other groundwork on which to base opinion. Attempts to educate the public tend to be met with apathy due to the lack of entertainment quality within these public messages. Public presentations regarding the reality of addiction simply cannot compete with contemporary entertainment. The final result is that the drug addict is perceived as a criminal, and addiction treatment is considered a subordinate goal to that of eliminating the criminal, drug trafficking element from society.

A further influence which needs to be addressed at the outset is the traditional separation of alcoholism and addiction as two separate quantities. Alcoholism as a public problem has been with us for some time, and it stems from an individual's inability to control a legal substance. Addiction, on the other hand, is interpreted to involve illegal substances, and the addict is then guilty of the further infraction of breaking the law each time he or she uses. Even the enlightened members of Alcoholics Anonymous tend to view the addict as alien to their program. Addicts are judged to be worse than alcoholics if for no other reason than the fact that addicts use illegally obtained substances. But the perceived difference is more one of prejudice and intolerance than of real distinction.

Treatment programs today approach alcoholism and addiction with identical treatment schemes, and treatment professionals further screen all patients for both alcohol and illegal drugs as a deterrent to cross-usage.[5]

Insomuch as this project primarily addresses adolescent chemical dependency, the distinction is further flawed. Most young patients are diagnosed as poly-drug dependent, which includes alcohol, even though they may have a particular drug of choice.[6] Whether children use alcohol or other drugs they are guilty of breaking the law. Either is illegal for them. The chemical of choice for a juvenile quite often becomes a matter of expediency, with the choice being for the more easily obtained substance.

It is likely that most people know someone who has had a drug or alcohol problem, and the likelihood has increased over the past decade that it is a young person who has had such a problem. As mentioned in Chapter 1, roughly one out of every six teenagers is addicted.[7] With this in mind, any misperception regarding the complexities of addiction and treatment could become an obstacle to effective

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[5] Frank N. Thomas et al., "The Strategic Use of Urinalysis in the Treatment of Adolescents in Family Therapy," Journal of Strategic and Systemic Therapies 6, no. 4 (Winter 1987): 1.

[6] Norman A. Krasnegor, Adolescent Drug Use: Suggestions for Future Research, National institute on Drug Abuse Research Monograph Series, no. 77 (Rockville, Md.: National Institute on Drug Abuse, 1988), 128.

[7] Youche and Seicas, 142.

treatment of a young addict. All one needs to do is consider the probability of having that young addict within their own household.

The Problem With Treatment Programs

Traditionally, treatment for the adolescent begins after some form of intervention which was precipitated by a a crisis in the individual or family. The crisis could have been the theft of the family car, arrest or incarceration, violence or threats of violence, a suicide attempt, or other event invoking attention from parents or caretaker. The subsequent intervention could be as simple as parents delivering their child to a treatment center and demanding assistance, or could be more formal, involving a lengthy assessment by a professional staff. No two interventions are the same, and any action which results in an individual's being admitted into treatment can be called intervention. Yet the quality of the intervention procedure does play an important role in the quality of the subsequent treatment. The admitting staff have the responsibility to ensure that a new patient is appropriate for treatment, that the patient's needs can be met at their facility, and that the parents are fully informed of their responsibilities.

Intervention is where many treatment programs begin breaking down. Treatment programs are expensive and require a relatively full quota in order to maintain an adequate financial base. Many patients are accepted into treatment

under less than ideal conditions as a result. The patient almost always needs the care, but many prerequisites of a successful course of treatment are left to be dealt with at a later date. Once the impact of the initial crisis has passed, the patient and family are often unwilling to submit to a regimen of therapy adequate to offer success. The result is a high rate of treatment failure and relapse, dissatisfied parents, and an even more difficult adolescent.

The personnel of some programs insist on a complete pre-treatment screening and evaluation before formally admitting a patient. They may require certain contractual obligations from parents or family which insure some level of participation in the process. But addiction treatment has suffered due to serious cutbacks in health insurance coverage and government support. Many facilities have shut their doors or shifted their emphasis to other diagnosable conditions, while some have adopted dual diagnosis as a means of continuing to offer treatment. All of this creates a frustrating conflict for professionals genuinely concerned for patient treatment and recovery. These pressures, which are addressed in the next section, help to explain why few hospitals or treatment programs effectively manage addiction recovery from a family perspective.

In concert with what has already been discussed, public sentiment still considers the addict or alcoholic singularly responsible for his condition. Many people characterize

addiction as being the result of moral or character flaws, with issues such as family history being an excuse. For the past twenty or so years, though, professional opinion in the field has been cognizant that addiction is the result of several significant factors, including family history and functioning, external environmental influences, and heredity. In 1976 Joseph Kellerman published Alcoholism: A Family Illness in which he directly identified the needs of the family and the fact that the disease resides in the family.

> We must change the present approach to alcoholism which focuses on the alcoholic and virtually ignores the needs of others. Alcoholism is a family illness, a family disorder, and never an illness in one individual. . . .Of primary importance is the fact that the families of alcoholics - the spouse, children and others - desperately need help for themselves, not primarily to become agents of recovery for the alcoholic, but to free themselves from the enslavement of alcoholism and to become human beings again in their own right.[8]

Treating the family has become a vision today, as evidenced by the many publications on the subject. This vision has value not only to the addict but, as Kellerman points out, also to the family of the addict. Stanton and Todd consider family treatment to offer the most promising possibilities for developing treatment modalities which will effect successful change, or recovery. One of the underlying goals of their research was to adequately conceptualize drug abuse

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[8] Joseph L. Kellerman, Alcoholism: A Family Illness (New York: Alanon Family Group Headquarters, 1976), 5.

as a family phenomenon.[9]

Of course, professionals in facilities and community programs do emphasize the importance of involving family in the recovery of addicted individuals, especially children and adolescents. At the same time, they maintain the primary focus on individual responsibility to recovery, which is the correct posture. These professionals do attempt to influence the family to become involved in the individual's treatment, and they also treat the individual in a manner intended to increase awareness of the family's input into the condition. But few professionals insist that the family be closely involved in all stages of treatment and recovery, and few treat the family as the co-facilitator of addiction.

It is essential that the family be considered as an addictive environment. The term co-facilitator, as used above, provides meaning beyond the term codependent. Alanon, a twelve-step self help program for family members of addicts and alcoholics, uses the expression codependent to describe the relationship of non-addicted family members to the addicted member. It describes the family behavior which supports or encourages addicted behavior. The term co-facilitator, on the other hand, indicates a symbiotic relationship in which one pattern of behavior might not necessarily exist without the other. Stanton and Todd

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[9] Stanton and Todd, 11.

describe this behavior as an "interdependent process" in which the addict's failure serves to protect the family as as a unit. One of their major conclusions is that the addiction itself provides what they call a paradoxical resolution to the dilemna of maintaining or dissolving the family.[10]

Stanton and Todd also characterize addictive families as overly enmeshed. Members often describe family relationships as extremely close, with nurturing, often infantilizing, behavior toward one another.[11] In their testing they note that addicts' families are much more likely to demonstrate overlapping roles, and that mothers tend to remain at an earlier stage of childrearing, often holding on to their children and treating them as younger than they really are.[12]

The enmeshment described above, though, has the capacity to become an assistant in recovery. Pamela Clapp, in an article applying Terence Gorski's developmental model of relapse and recovery, indicates that possibly the most important factor in guaranteeing recovery in adolesecents is family involvement: "Without that support, the adolescent is left alone to face nearly insurmountable obstacles, lacking

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[10] Stanton and Todd, 16.

[11] Stanton and Todd, 13.

[12] Stanton and Todd, 15.

both the life skills and the maturity to overcome them.[13] Clapp continues by adapting Gorski's six step recovery model to adolescents, and demonstrating in which areas family support seems to be most useful. Other models, such as one developed by Anchor Hospital in Atlanta, Georgia, also use adaptations of Gorski's model.[14] Anchor requires that family members participate in group sessions throughout all levels of care. These treatment models will be examined more thoroughly in a later chapter.

The importance of the family is recognized by most treatment programs, but the primary problem lies in obtaining family commitment and support from the start and maintaining it through treatment and aftercare. Hasty admitting procedures and lack of continuing encouragement or support are the most frequent causes of poor family participation.

The Crisis in the Treatment Industry

Costs can be prohibitive for inpatient treatment, and many insurance companies have canceled or seriously curtailed funding for chemical dependency treatment. A recent report regarding managed care and cost containment indicated that many programs, both freestanding and

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[13] Pamela Clapp, "The Long Road Back," Student Assistance Journal 10, no. 1 (January/February 89): 27.

[14] Martha A. Morrison et al., "A Comprehensive Treatment Model for Chemically Dependant Adolescents: Part Two," Professional Counselor 4, no. 5 (March-April 1990): 48.

hospital-based, have closed, and that others are up for sale. This trend is attributed to pressure from the insurance industry and employers to reduce health care costs.[15] The future in this regard is even more threatening. Addiction treatment has been recognized as having a big business potential, and in the recent past was growing at an incredibly fast rate. Hospitals opened treatment units, and specialists built and dedicated treatment facilities. But treatment costs rose and insurance companies began taking a closer look. They concluded that if they were to continue funding treatment at all, shorter inpatient stays and lower overall expenses would have to follow.[16]

This direction has continued until we are at a point where the majority of insurance companies no longer fund primary care for chemical dependency. In a recent interview Sharon Wegscheider-Cruse, a pioneer in family recovery, made the following assessment of the dilema:

> Politically, because of the economics of the time, because of the fact the field has not done a good job of documenting, doing research and coming up with the data that makes insurance companies sit up and pay attention; [because of these shortcomings,] the whole addiction field has been going backward the last few years. Treatment centers are closing all over the

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[15] Ed Hearn, "We're Getting Clobbered," Professional Counselor 4, no. 5 (March-April 1990): 39.

[16] Hearn, 15.

nation.[17]

In an attempt to avoid closing, psychiatric hospitals and treatment programs with a psychiatric staff are changing their treatment methodology, such as switching to the dual diagnosis mode. Dual, or multiple, diagnosis has kept many treatment programs in business, but is even now being more closely scrutinized by insurance providers.

During this same period, the Federal government was establishing the Office of National Drug Control Policy, as the administrator of the President's "War on Drugs."[18] The majority of the money for this project was being earmarked for the prevention and interdiction of drug trafficking, but the policy still identified treatment and "demand reduction" as a target. Demand reduction was the title selected for the strategy which concerned itself "with reducing the demand for illegal drugs, which includes treatment, prevention, education, rehabilitation, and research."[19]

In an interview last year, Herbert Kleber, (M.D., Deputy Director for demand reduction at the Office of National Drug Control Policy), identified the objectives his office had for the treatment industry:

> On the treatment side, I want to do two things simultaneously. We need to expand the treatment system

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[17] Milt Schwartz, "Sharon Wegscheider-Cruse," Sober Times, January 1992, 18.

[18] Kramer, 54.

[19] Kramer, 54.

> and get rid of waiting lists, but at the same time we need to improve treatment. . . .We need better treatment-client matching. I would like to see more centralized treatment evaluation and referral mechanisms. . . .We need to hold programs accountable. . . .At the same time, I think we also need a hold-harmless policy (relating to the degree of severity of the patients being treated) to avoid penalizing programs that take more difficult patients. . . . Finally, we need more research to discover not only what works but more effective ways of providing treatment.[20]

These ideals, though, do present the possibility of an expensive and bureaucratic system weighted by its own checks and balances. The mechanism to manage all of this could cost a lot of money and be ineffective.

Kleber expressed that he felt very supported by the general population, and that an aggressive posture regarding treatment shortcomings is in order:

> I believe the people of this country are very supportive of reducing drug abuse in America. They are willing to put pressure on Congress to provide the necessary resources and willing to work in their own communities. The outpouring of support from people who want to be helpful has been great. What I want to do is make a substantial impact on the demand side of the reduction of drug abuse.[21]

Politics appear very important here. Is the impression upon the public the real issue? What will the public accept when the costs of managing this system become apparent? If the goals described above can be funded and implemented, will the government allow chemical dependency treatment to continue to develop on its own natural course, or will it

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[20] Kramer, 55.

[21] Kramer, 56.

impose restrictive rules.

Kleber's closing remarks address a part of the drug controversy which has little connection with the purpose of his department:

> This is an eminently winnable fight. I would urge people not to succumb to the siren song of legalization. I think legalization is a bankrupt idea that basically attacks what we as a country are doing as unworkable, without proposing any workable alternatives.[22]

It is interesting that he would use any time in an interview regarding treatment to address legalization. The legalization of certain banned substances, particularly marijuana, was an issue several years ago. It surfaces now, around election time, but has such limited support as not even to qualify as a political agenda. In addition, treatment and recovery of chemically dependant people makes no distinction with regards to legalization. It is not a treatment issue.

Such is the state of the treatment industry today: saddled by increasingly high expenses, strangled by insurance industry restrictions, and threatened by government intervention. The effects of any one of these variables could restrict the improvements seen in the treatment industry. But the treatment industry is not the foundation of recovery. Recovery will continue, as it did before professional alcoholism and addiction treatment

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[22] Kramer, 57.

became the industry it is today. The position of professional treatment facilities within the framework of recovery will need to be reassessed, however. Can professional programs integrate the latest concepts which incorporate family into recovery, and can they operate within the financial constraints yet to come? If they fail to respond, though, who will pick up the lead? The need for intervention, treatment, and recovery is greater than it has ever been. Perhaps individual communities and their organizations, including churches, will find that they must assume leadership in this arena.

CHAPTER 3

Communicating Addiction

Addictive Systems

Even to this day addiction and alcoholism are treated within the traditional church setting as a moral issue. Members talk about their immoral neighbors and their uncontrolled drinking or drug use, or they gossip secretively about the addict or alcoholic within one of their own church families. Even churches which accept social drinking maintain a "bad other" perspective with regards to chemical dependency. Yet there is a good chance that most churches are impacted by alcoholism and addiction at about the same rate as the general population.

As research and studies of addiction in its various forms continue, more and more compulsive behavior patterns are being considered within the scope of addiction, and more family patterns are being considered as fertile environments within which addiction can grow. In comparing addictive families to other families with severe dysfunctions, Stanton and Todd note:

> There is evidence for a higher frequency of multigenerational chemical dependency, particularly alcohol, among addict's families, plus a propensity for other addiction-like behaviors such as gambling and

> television watching. . . .Such practices can provide modeling for children and can also develop into family "traditions."[1]

Sarah Hines Martin, in her recent book Healing for Adult Children of Alcoholics, describes some of the characteristics of the alcoholic personality. Among these are sensitivity, anger, compulsiveness, paranoia, perfectionism, and controlling.[2] These characteristics are not uncommon to church members, regardless of whether addiction or alcoholism is present. In addition, being a member of a family which belongs to this or that particular church may be very embarassing to an adolescent seeking peer group identification, or it may result in their not being allowed to establish a viable peer group association at all. A child may seek potentially dangerous acceptance from the outside in the same way a child from a more obviously troubled family might. The church, especially when it postures itself as rigid and unforgiving, can lose its call to nurture and care.

Martin, in an attempt to circumscribe behavior and patterns common to alcoholic families, describes her perspective on dysfunctional family living. As examples of dysfunctional families, she includes homes where a parent is chronically ill or mentally ill, where a parent has died and the other is overcome by grief to the point of temporarily

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[1] Stanton and Todd, 14.

[2] Martin, 11.

ceasing to function as a parent, a home where physical or sexual abuse has taken place, a home with an adopted child, and a rigidly religious home. In her estimation, these families focus on a problem, addiction, trauma, or some secret rather than on individuals or the child, and they become a shame- or blame-based home. She contrasts these homes to normal homes, which fulfill the parental tasks of work, relationship to one another, and raising children, giving childrearing the appropriate amount of attention.[3]

A complicating problem is the lack of understanding of what dysfunction is. Almost all writers in the fields of family therapy or social work use the term, and it is used daily by individuals seeking to describe their family of origin. But almost all explanations of dysfunction in families comes from the individual's own experience, either within his or her own family, or from experience as a therapist or social worker. From a purely mechanical point of view dysfunction is the employment of anything, whether natural or manufactured, in the performance of a role for which it was not designed. As an example, if a chair, designed for the seating of human beings, is used to hold boxes, it is being employed in a dysfunctional manner. Although it is still serving a function, that function is not appropriate to its design.

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[3] Martin, 34.

Dysfunctional families, then, find their members performing roles or functions outside those established by their cultural standards. In alcoholic families, the dysfunction occurs when children perform parental tasks, or take over the role of parenting the helpless parent or parents. Other obvious dysfunctions can be observed in the examples used by Martin above. But even in otherwise healthy families, dysfunction can occur at subtle levels when children have greater expectations placed upon them than the cultural norm, or where one or both parents fails to fulfill all of their expectated roles, therefore leaving a gap to be filled by another family member. These subtle differences can cause confusion and blurring of boundaries and expectations, leading children to grow up too soon rather than mature along a natural course. While addiction or alcoholism in a family can create obvious dysfunction, which can be identified and treated readily, the more subtle dysfunctions can create similar dilemmas for adolescents and young adults, but with much more difficulty in assessment and treatment. Quite possibly, a person from a normal family might suffer from low level depression, anxiety, mild compulsive behavior, or some other disorder at a level not causing a serious enough problem to consider treatment but otherwise rendering their life relatively miserable.

One of the categories which Martin listed as an example

of dysfunctional families was the rigidly religious home. She qualified her use of this example by stating that dysfunctional dynamics occur because children are not valued for themselves but are raised by rigid rules.[4] The outcome is that individual functions are not defined by cultural or social norms, but rather are displaced completely by a requirement to adhere to rules. The value and acceptance, or acknowledgement, of a child, then, is not based on his or her intrinsic value. A child in this setting cannot grow along the normal path of experiential learning, but must immediately be all that the rules require. Any deviation from the rules leads to rejection in one form or another, and the immediate devaluation of the child in his or her own eyes. An inability to perform at levels beyond age-appropriate ability are not considered, and the result is a weak or nonexistent sense of self and a blurring of parent/child boundaries.[5]

The Sick Child: The Family Symptom

The following section builds upon ideas which developed as a result of personal experience, and will include some case histories of teens who were admitted into treatment for drug dependency. These cases are all documented by personal observation, and are intended to demonstrate some

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[4] Martin, 34.

[5] Martin, 36.

of the various parent-child dynamics which appear in addiction-prone families. (The names have been changed, and any unnecessary personal information which might identify a specific patient has been left out or altered.)

Glen entered treatment when he was sixteen. He came from an intact family which lived in an upper class neighborhood of a coastal suburb. His father was a stable, non-alcoholic executive who worked for a large pharmaceutical firm. His mother performed more traditional roles and did not work. Glen had one sister, and they both appeared to have lived relatively trauma-free, well adjusted lives through their early childhood. Glen was extremely outgoing and personable, demonstrating above average intelligence, and he seldom displayed anger. Nearly all of his personal and interpersonal behaviors were appropriate. He was diagnosed as chemically dependent, with his primary drug of choice being crystal methamphetamine, although he would use alcohol and other drugs when they were present.

In treatment, both parents participated in family therapy and consultation with the treatment staff. After treatment, though, Glen's father was more active in his recovery than his mother. His sister did not participate at all. During the inpatient phase of treatment, both parents were required to participate in multi-family group sessions. One of the goals of those sessions was to attempt parent-child rebonding as a support to long-term recovery. Most of

Glen's effort in this regard was directed toward his father. His mother was normally quiet and did not interact with other participants in the group. After inpatient treatment, she quickly stopped attending the aftercare program, and disengaged herself from Glen's recovery.

Stanton and Todd noted in their research that families with adolescent addicts often have trouble transitioning the adolescent passage, during which a teenager moves toward stronger peer group affiliation. This passage includes a movement away from the family:

> The family is in a state of crisis, and the problem manifested by one member is an attempt by the system to resolve the crisis. In other words, the symptom is indicative of or part of a "problem in living" involving the entire family.[6]

Glen's addiction possibly served as a tool for his transition, forcing a crisis in his family which allowed him to place distance between himself and family control. His mother's failure to support his recovery after his release from treatment could be interpreted as an attempt to return the family to its former stability. Another issue arises, though, which was not observable before: the threat of abandonment. The response of Glen's mother served as a message to him that if he continued to change, even if that change was healthy growth, she would no longer participate in his life. The threat of abandonment appears as a tool of control in many addictive families.

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[6] Stanton and Todd, 339.

Jamee was raised by her mother, and never knew her father. Her mother was an airline stewardess. She was away from home a lot, and lived a very social life when home. As a result, Jamee spent a great deal of time in the care of others. By the time she was fourteen she was living full time with her grandmother. Jamee described her mother as "schizophrenic," with episodes of mania and depression, during which she would go on spending sprees or search for new boyfriends. Jamee never experienced a stable childhood, and had difficulty with interpersonal relationships. She would become dependently attached to a specific individual, such as a boyfriend, and would then become alternately possessive or rejecting. She entered treatment for addiction when she was fifteen.

Jamee was admitted into treatment by her grandmother, who participated in some family group functions. Jamee's mother never became involved in her daughter's treatment, although she would visit occassionally. During the multi-family groups Jamee's grandmother attended with her boyfriend, who was identified initially as her husband. After she completed inpatient treatment, her grandmother stopped attending, but her grandmother's boyfriend continued as a parental or guardian support. His support was very instrumental in the initial phase of her recovery, yet Jamee's interpersonal relations suffered, as she had no experience of a nuclear family environment.

Jamee demonstrated alternating affectionate behavior. She would seek closeness and intimacy one moment and then reject it the next. Martin indicates that alcoholics are emotionally needy and yet unable to handle emotional closeness:

> One message the children receive is, "Come close-go away." ACA's [adult children of alcoholics] find themselves with a contradictory need to be close but feeling uncomfortable with closeness.[7]

Jamee was an addict and the child of a parent who demonstrated addicted or alcoholic behavior. As mentioned, her mother never participated in her recovery, and she was never interviewed by the treatment staff. Therefore, an accurate portrayal is impossible. But the sense of abandonment and loss was apparent in Jamee, as was her difficulty with intimacy and affection.

In an earlier era the addict in any given family was an adult and was called an alcoholic. In the past two decades, the age of onset of addiction has decreased drastically. Children are being admitted to treatment programs as young as twelve years old, and occasionally even younger. Being raised in an alcoholic or addicted family severely increases one's own odds of becoming addicted, although juvenile addicts occassionally come from families without apparent addiction. The root of an adolescent's addictive behavior may lie in some multigenerational schema of addiction which

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[7] Martin, 74.

has skipped a generation, or may proceed from other dysfunctional family formats, as described by Martin.

Children and adolescents do not possess adequate judgment to comprehend social or controlled drinking, nor judgment to manage drug use. Obviously, a massive number of adults cannot regulate it either. Some young people manage to escape their adolescent years unaffected by addiction while others fail. The answer is not simply a matter of stressing and restressing rules which restrict or control use, and it is not simply a matter of raising a child in a safe, stable neighborhood. Even parents who vow to raise their children in caring, nurturing households are producing young addicts. These parents sometimes become the most intractable when they enroll their young addict in treatment. They now look back on their promise of parental excellence with shame and guilt.

Glen and Jamee come from radically different backgrounds. Their family experiences are on different ends of the spectrum. Their respective recoveries, though, took very similar courses, including periods of intense emotional instability and threats of relapse. They both verbalized intense abandonment issues, and acted out in attempts to draw their families' attention. Once they gained some level of attention, either from their family or staff, they returned to reasonable behavior. Upon intake their fear of abandonment was not obvious, but became apparent only after

close observation in treatment.

In future analysis, experts may find that all factors and treatment issues are more closely related at their roots than we now accept. The underlying source of these issues could be one big hard-to-find wellspring of addiction-creating turmoil. But whatever the causes, children still become addicted and require immediate attention. One psychiatrist stated that if he had the time and resources, he could quite possibly effect a cure of the etiological factors underlying any given addict's behavior, and therefore cure the addiction, but the patient would be dead from the addiction well before that time. Addiction is deadly, and requires immediate treatment.

One of the more glaring characteristics of parental attitude is the distance they place between themselves and their child's problem. The young addict is sick and needs to be cured. The initial posture of many parents is that they are present to tell the doctors of their frustration and confusion regarding the behavior of their child, and they are prepared to pony up the necessary funds to set this little problem straight. In addiction terminology, this characteristic is identified as denial. Denial begins breaking down when parents decide on treatment, but the collapse of denial is a process, and occurs over time. Clapp identifies this as "A time of confusion, perhaps even desperation, during which the family has basic but urgent

needs."[8] Mom and Dad do not consider themselves, at least on the surface, to be part of the problem. They certainly would not consider themselves the source of the problem.

As a young addict moves through denial and begins to accept the fact of addiction, family denial impacts him or her in two primary ways. First, parents themselves have a difficult time accepting that their child is addicted. They hope their situation is a transitory problem: their child is not an addict. Their initial responses tend to pull their child back into the envelope of denial. The second impact of family denial occurs when the addict begins to see how family dynamics have shaped him or her. Treatment programs today stress education into the systemic quality of the family environment, and the addict generally sees the family as an addictive system long before other family members become aware of it. In a large number of cases parents may never fully accept their impact on their child's addiction, causing a great deal of additional pain and anger for the addict.

Family denial, however, is endemic to the dysfunction which has permeated the system. J. C. Wynn describes a family frought with crisis, wherein one or the other of the children would act in a dangerous or antisocial way whenever the marriage was on the verge of dissolution. Though this happened repeatedly, the parents never saw the pattern until

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[8] Clapp, 27.

they entered therapy. Wynn noted three important points about this pattern:

1. That the family was in a system which allowed the behavior of one member to affect the behavior of the others, which in turn doubled back and affected everyone again in a different way.

2. That the children's behavior, or crisis, brought the family back into their familiar, although uneasy balance, called homeostasis.

3. That the unnoticed nature of this game enabled the family to play by rules which required one member to make a disastrous move whenever family cohesion was threatened.[9]

The family system itself takes on a sort of personality and consciousness. If the system senses a threat, the family will act in some fashion to protect itself. Some families are even prepared to discard a member in order to preserve cohesiveness and learned stability.

Many times a family will present its sick member to the world in order to protect itself from examination and to protect the system's cohesiveness. But the adolescent addict is not the primary problem, although he or she needs immediate attention the most. The family itself is the primary problem, and the addict is simply the current symptom of sickness. Kellerman claims individuals do not

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[9] Wynn, 27.

get sick emotionally, mentally, socially, or spiritually:

> One person can play the "sick role" successfully only if other members of the family play supporting roles. One member cannot remain sick without the collusion of the family.[10]

The Sick Family: Preserving the System

Two laws of physics appear to describe the binding force of dysfunctional families. One is the law of inertia: that any object or mass in motion will tend to stay in motion, and any object or mass at rest will tend to stay at rest. Translated into family life, many people simply do not want to change. Martin states that "Some people do not want their problems solved! They enjoy self-pity and resent attempts to remove the problem from their lives."[11] Whatever their particular state of affairs, they want it left that way.

This resistance to change is aided by the fact that dysfunctional, addictive families are also resistant to outside intrusion. Martin describes this as a "closed system, where no one comes in from the outside and those inside don't go out."[12] They are secretive even among themselves, not talking about something that may be obvious to an outsider. They protect their family homeostasis by

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[10] Kellerman, 11.

[11] Martin, 64.

[12] Martin, 46.

avoiding disruption from outsiders and insiders.

The second law of physics which has utility is the law of gravity as it applies to fluids: water seeks its own lowest level. Members of dysfunctional families, in the same manner, will tend to be drawn to the level of their lowest functioning member. Any prominence from a member is unappreciated as it draws attention from the outside. Alcoholic or addicted behavior is met with suppression or silence. "Dysfunctional alcoholic families are cut off from the outside by the desocialization of the alcoholic [or addict]."[13] Once the system closes and begins acting upon itself, members may find themselves disabled by the actions of the addict. They begin making excuses for him or her, covering up or cleaning up in the wake. In addition to the shame, they become too busy managing the internal environment to maintain outside contacts.

These two laws, when operating in families, tend to be antithetical with one another. The first rule is not sympathetic with the second. If the system tends to like to stay the way it is, yet one member has the power to alter the stasis or inertia of the system, then there is bound to be a crisis. The system, or family, is approaching self-destruction, and on occasion the crisis will be grave enough to destroy the family. Some family systems are willing to

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[13] Martin, 47.

discard one of its members. Other families may hold on until the system bursts.

Alycia was fifteen when she entered treatment for the first time. She came from an intact family, although her father travelled a great deal. Her parents seemed to have a distant relationship. Throughout the course of treatment and aftercare, the only parent who showed up for family sessions or group was her father. Her mother was always too busy with the family business. In the four years I observed her recovery I never once saw her mother. Yet it appeared from what I saw in group sessions that her mother was the most powerful member of her family. Her mother was treated as a matriarchal figure, and was never spoken of negatively. Alycia talked about her mother more than her father.

Alycia was overly dependent, emotionally clinging to her father whenever he was present, or physically clinging to a boyfriend she met in treatment. When her boyfriend relapsed, she decided to relapse along with him, expressing that she did not want him to be alone. When he threatened suicide, she threatened also. In time, her father's participation in the family portion of her recovery tapered off and ultimately ceased altogether. She had been abandoned.

It was a real surprise when Alycia told me that she was still working in the family business, and that she lived in a small cottage located on her parents property. When I

asked her about her family she always avoided any substantive issues, such as family togetherness, separateness, agreements, or fights. She would only discuss her family in indefinite terms, glossing over family life with sweeping generalizations such as "great" or "marvelous." In her years of recovery she did not discuss specific interactions of the members of her family except to explain their whereabouts. She developed obsessive, clinging relationships with boyfriends almost immediately upon meeting someone she was attracted to, and she dissolved them equally fast. Alycia has never addressed the fact that her family abandoned her. She is effectively dead to them. She has since ceased working at the family business although she still lives in the same cottage.

Cementing family cohesiveness within dysfunctional, addictive or alcoholic families is the underlying fear of rejection and abandonment. Many therapists argue that the greatest evil in families is physical and sexual abuse. But the pressure young people are willing to endure in order to be accepted or retained by their family suggests that the greatest evil which can be perpetrated upon a child is abandonment. An adolescent's willingness to endure cruelty and harshness is not simply the result of learned helplessness, learned behavior, or fear. At the root of such behavior is the fear of being utterly abandoned.

Martin asserts that in all dysfunctional homes, the

basic issues for children are abandonment and rejection. She quotes Cathleen Brooks, president of the National Association for Children of Alcoholics, saying that "emotional abandonment is the worst kind, even more devastating than physical abandonment."[14] Alycia was emotionally exiled from her family - - forced to live in a cottage on her parent's property while being cut off from emotional support. Despite her sensitivity and intelligence, she became vacuous in her attempt to mask her loss. She so feared the terror and grief of facing her rejection that she blocked her deeper emotions. When she first appeared in therapy she was emotional and showy, histrionic, but as her family drew more distant from her, she simply appeared lost. Although she always presented her smiling, active personality, she followed anyone who acknowledged her or offered her the comfort she sought, and her emotionality appeared to be very shallow.

This fear of abandonment is empowered by the very nature of dysfunction in a family. As already mentioned, dysfunction is the inappropriate use of something or someone. In a dysfunctional family the members are busy performing each other's roles. As one member fills in for the missing or sick member, another member fills in for what the first co-functioning member is failing to perform, and so on. With members of a family system performing roles in

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[14] Martin, 36.

an inappropriate manner, the children grow up with a very sparse sense of self. A child with a fragile self-esteem and a weak acceptance of his very existence uses the family bond to validate his or her own existence. To be abandoned, to this child, is to confirm his non-existence. The fear of this abandonment would obviously be terrifying.

Stanton and Todd noted this characteristic at the outset of their research. Upon examination they discovered that the fear of separation was the power behind family dysfunction in addicted families.

> On looking further, however, we started to notice that when the addict began to succeed - whether on the job, in a treatment program, or elsewhere - he was in a sense heading toward leaving the family, either directly or by developing more autonomy in general. What was interesting was that at this point some sort of crisis would almost inevitably occur in the family. . . .We observed this pattern so frequently that it became clear to us that not only did the addict fear separation from the family, but the family felt likewise toward him. . . .His failure served a protective function of maintaining family closeness. . . .The members seemed to cling to each other for confirmation or perhaps a sense of "completeness" or "worth."[15]

Children raised in healthy families receive affirmation throughout childhood. Even when they cross the line and are punished as the result of inappropriate action, the response is received as affirmation. They may be angry at their circumstances, and may chaff at their parent's protectiveness, but there is always an awareness that they are loved and accepted for their very existence.

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[15] Stanton and Todd, 12.

Children raised in severely dysfunctional homes, on the other hand, perceive themselves as having value only as the result of their utility. When they are punished, they perceive it as a warning of possible abandonment and rejection. Every act of non-acceptance to these children is an act of rejection, a precurser to abandonment. They have no comprehension of their intrinsic value.

As noted earlier in this chapter, Wynn describes how dysfunctional families operate within their system of sick cohesiveness, which he calls homeostasis, involving a cycle of threat and crisis.[16] The self-image of each family member is preserved within their dysfunctional roles. The cohesiveness, or glue, which binds family members to the cycle is the underlying fear of abandonment, and this fear results from the dysfunction itself.

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[16] Wynn, 27.

CHAPTER 4

Recapturing the Family

If we take a close look we will find that we have a multitude of families which fall into the dysfunctional category. Life in this country, or in Western culture for that matter, has not produced an overabundance of healthy family examples. In fact, many of the seemingly benevolent forces and agencies in our country work directly against family life and healthy families.

John Wynn expresses a strong criticism of the future of the family as dictated by national sentiment and policy. Although the United States has no national family policy as does Canada, he says that a policy is inevitable. The sheer mass of social agencies and programs, each operating with its own goals and ideals, sometimes in direct conflict with one another, will ultimately result in some umbrella agency which will establish policy and direction.[1] In many cases the policies are forcing families apart: housing policies which give priority to single parents, welfare regulations which make it profitable to disassemble a family, and tax policies favorable to singles.

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[1] Wynn, 10.

Make no mistake about it, Wynn says, we shall inevitably forge a national policy, and when we do, it could be terribly restrictive[2]. Government intervention in family life has already produced negative consequences to the family, yet social-minded people still tend to think that more government will produce favorable results. I doubt that is likely. But the real issue to be addressed here is what to do about the family today. Do we disassemble and discard dysfunctional families, or do we pick a certain level of dysfunction above which we dismantle a family? Where do we draw the line?

A Healthy Vision

The discussion so far has dealt with the strength of the homeostatic condition of dysfunctional families, their unwillingness to allow intrusion or change, and their relative comfort with their own sickness. This chapter attempts to provide a backdrop from which to frame a concept of family health. In reality, defining a healthy family is difficult. There are examples around us, and yet when asked to describe what constitutes health, many differing answers arise.

Many dysfunctional systems are created as the result of an attempt to live within the framework of a particular concept of family health. These families may develop into

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[2] Wynn, 11.

the rigid, rules oriented families mentioned by Martin.[3] They suffer as the result of a system of rules requiring particular behavior from each member, while failing to affirm individuality and worthwhileness of that member. In support of Martin's argument, Jim Larson attests that in the dysfunctional family "There is little concern for the welfare or esteem of its members, but rather a focus on their performance.[4] Consequently, any attempt to define or circumscribe family health should be approached with caution, in order to avoid the use of that definition as the groundwork for a new set of oppressive rules.

The research of Chapter 3 indicated one notable difference between children of healthy families and children of dysfunctional families: Children raised in healthy families have a strong sense of their own intrinsic self-worth while children raised in dysfunctional families have a sense of value only within the framework of their family role. As a result, one child feels loved by virtue of his or her very existence while the other feels worthy of love only when meeting the requirements of his or her assigned role. The fact that these roles are ill-defined and fluid in a dysfunctional home make it virtually impossible to feel worthy of love, or lovable.

Following are two concepts of family health, one by

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[3] Martin, 34.

[4] Larson, 27.

Sara Martin, who describes healthy families by virtue of their being open systems, and the other by Herbert Anderson, who also presents family health by its open nature, but with the added feature of interdependence of family members with one another and with their larger communities.

Sara Martin describes relative family health on a continuum, originally developed by Virginia Satir. This continuum is terminated at one end by the closed family system, and on the other by the open family system. In between, and along the continuum, are the various degrees of troubled family systems.[5] The closed system, as its name implies, does not allow its members out into the world and does not allow intrusion into its privacy. The open system allows much coming and going. The family develops a strong network with others outside the nuclear family, and lacks the paranoia regarding intrusion which blocks the closed family.

Martin states that if you turn all the negatives regarding dysfunctional families to the flip side, it will provide details as to the positive ways families operate. Her list includes:

A positive climate. The atmosphere is nonjudgemental.

Each person is accepted with regard for his or her individual characteristics.

Each person operates within his or her proper role.

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[5] Martin, 46.

Members care for each other and affirm each other.

Family members use open and direct communication.

The family produces children who can separate; individuation occurs.

Families come together out of choice.

Members operate within clear, firm boundaries.

The atmosphere is safe so that members can function spontaneously with humor and wit.

Intimacy is achieved. This requires people to make themselves vulnerable by their commitment and self-disclosure.

They share personal secrets and fears while trusting the other persons to continue to care about their feelings. They also commit themselves to being careful of the other in the same way.[6]

Anderson presents his concept of family from a theological perspective, but warns that "The pastoral theologian's agenda is not to identify a 'Christian family' but to help people find ways of being Christian in families."[7] In fact, families which identify themselves as Christian may be in danger as a result of potentially rigid rules and boundaries, effectively closing off young members from free interaction with the external environment. The family is not autonomous, and must interact with the general environment. Therefore that environment, which has its own authorities, also defines the family, according to

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[6] Martin, 47.

[7] Anderson, 15.

Anderson.[8]

Anderson also uses paradoxes, or contradictions, in the form of a dialectic to circumscribe family. The principle of the dialectic, with its imperative for change, has interesting applications. The first dialectic involves:

> The delicate balance between attention to the individual and attention to the unit as a whole; the health and vitality of a family is finally determined by how its members learn to be separate together.[9]

In other words, the individuation of each member, his or her relative growth and ability to function autonomously, is essential to the health of the family as a whole.

The second dialectic is more theological. It melds the contradictory principles of family as an anthropological imperative, being an end in itself, and family as a theological step in the continuing process of creation, leading toward a kingdom vision:

> First,the family is a necessary component of creation. Despite wide diversity of form and function throughout human history, the family has fulfilled God's intent to provide a context for creation and care in order to insure the continuity of the human species. . . .It is the nature of things that people live together in those communities that we have labeled family. . . .Second, the importance of the family is qualified by the teaching of Jesus. From the perspective of discipleship, the family cannot be an end in itself. The metaphor of the realm of God is used here to point to God's intervention in history for purposes of continuing a process of transformation begun in creation.[10]

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[8] Anderson, 15.

[9] Anderson, 15.

[10] Anderson, 16.

From this perspective, Anderson continues to present a pattern for healthy family life which includes purpose and structure. He sets out three fundamental purposes of family (procreation, comminity, and individuation)and three essential characteristics of family structure (change, interdependence, and diversity) drawn from his presentation of paradoxes, or dialectic:

> Procreation, indeed any addition to a family unit(either in membership or function), produces change.
>
> The capacity to adapt to change is essential for the family's survival in relation to society as a whole and as a particular organism.
>
> The family is a stabilizing community that provides continuity in the midst of change.
>
> The vitality of the family, however, depends on an openness to its environment and on the interdependence of its membership.
>
> The focus of a family on individuation fosters the uniqueness of each member; never an end in itself, the family exists for the sake of individual growth.
>
> The promotion of individual growth within a family leads to a diversity within the family that is paralleled in the variety of family structures within society; such diversity is a sign of God's extravagance.[11]

The most prominent features of these two concepts of family is the stress on openness and individuation, although Anderson says that openness requires some caution, as the family needs the ability to close its posture for protection

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[11] Anderson, 17.

from time to time.[12] The family, as well as its individual members, needs to preserve the ability to negotiate between change and stability.

Family health, then, promotes in its members a sense of worthwhileness and love-worthiness. Roles are well defined, and members are allowed to grow and individuate. The problem now becomes one of how to get there. How does a dysfunctional family change? Simply trying to adapt these features to any given family poses the threat of a new set of guidelines, or rules, within which to dysfunction. Families with addicted children are generally approaching the closed end of the continuum described by Martin,[13] and they need hope that family health is possible.

Resighting the Objective: What is Recovery?

Throughout my experience I can attest to the fact that if a young person's family becomes directly involved in his or her treatment, and participates in recovery, the young addict has incredibly better chances of healing and sobriety than those without family support. Parents may struggle for several years with the continued addictive behavior of their child, but when they persist, however, the child ultimately begins genuine recovery. When parents are confronting and dealing with their own addiction creating dynamics and behavior, the change they undergo ultimately has a powerful

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[12] Anderson, 42.

[13] Martin, 46.

influence on their child.

Reggie resisted treatment with every ounce of his person. He was fourteen when he entered treatment, and had participated in a variety of antisocial behaviors including illegal drug use and addiction, drug dealing, burglary and theft. His mother, Monica, a single parent, struggled at first to know what to do with her son. He did not respond to treatment, attempting to run away on several occassions, and relapsing shortly after leaving treatment. But Monica stayed with her program, participating in parent groups which dealt with the variety of problems which parents of addicts must face.

Over the course of two years, Monica was forced to move Reggie into the garage in order to protect the rest of her household from him, and to give the police opportunity to conduct a legal search whenever she called to report her son for possession or dealing. Reggie's resistance to the idea of recovery seemed impossible to defeat. Yet Monica continued with her program, and became more and more healthy. Her methods of dealing with her son were appropriate, sometimes harsh, but always loving.

At the end of two years, Reggie showed up at aftercare with his mother. In the three years since that time he has developed his own plan for continued sobriety, become the chairman of the steering committee for aftercare activities, and developed an improving, healthy relationship with his

mother. Monica has become a strong part of her son's recovery, assisting him with each of the tough transitions he has entered.

Andrew, on the other hand, entered treatment with the idea that he was going to whip his addiction. He was small, angry, and had the kind of personality which dominated a room full of people. He approached everything in life like a pit bull, determined to kill it before it killed him. His perspective on life was that everything not him was a threat to him.

His parents participated in most of his treatment and were very active in aftercare. They quickly became versed in the language of recovery and codependency and began advising others as to how to deal with their children. They said they were there for Andrew and wanted to make sure he got all the help he needed. They were true to those promises, but they never seemed to perceive their need for recovery. Power and anger were big issues in their family. Andrew seemed to operate in perpetual motion, obviously hyperactive, with intense anger at the root of his motivations. His parents seemed to maintain power over him with criticism and rejection if he failed to perform as they wished, which was quite often.

Andrew struggled with recovery, relapsing on several occasions, injuring himself quite frequently as the result of self-destructive actions, and alienating himself from a

great number of his recovering peers. He ultimately managed to stretch temporary sobriety into long term recovery, yet his need to act in an unhealthy manner continues to follow him. He has difficulty keeping a job or friends, moves into and out of brief, volatile relationships, and always appears on the verge of relapse. From a clinical perspective, Andrew has retained all of his addictive behavior except drug and alcohol use. His family continues to operate with anger, confrontation, and threats as its primary style of communication. Andrew is the symptom of sickness within an addictive family.

Addiction cannot simply be stopped by taking the drugs away from the addict or by moving the addict into a drug-free environment. Recovery, in the same vein, is not simply the cessation of drug or alcohol use. Addiction is the result of an addictive response by an individual to his or her environment. If individuals are going to behave addictively, they will choose a convenient chemical or behavior and ultimately develop a compulsive pattern of abuse. If their first choice is not available they will find another, or another, and so on. It is not uncommon to find people in treatment for compulsive overeating who are recovering addicts, alcoholics or both. In the business this dynamic is described as switching addictions. Individuals being treated for alcoholism are often administered urinalysis, or drug screens, to prevent

substitute use of narcotics.

Healing from addiction, or recovery, requires a response from individuals in which they first admit their powerlessness over addiction, and then move to a point where they begin to understand that their addictive compulsion is not simply a lack of judgement or weak character, but rather a fundamental adaptive response to their environment, although they may describe the process in other words. They may learn that they have some genetic capacity to develop addiction, or that they have experienced modeled addictive behavior throughout their lives. They may lack coping skills adequate enough to survive on their own. They may discover enormous emotional pain and abandonment which they mask with their addiction, and they may discover that their addiction has been an excuse for other unacceptable behavior. They are quite likely to discover that alcoholism and addiction have plagued their families for generations.

Imagine an adult being forced to face the above issues and also to look at the destruction in his or her life. Full comprehension of so much trauma would require a lot of dedication on the part of any individual. Now imagine a fourteen year old boy or girl being faced with the same realizations. Occassionally, the realization of truth drives an addict or alcoholic deeper into destructive behavior. If the addict is a child, the yet fragile personality could suffer grave damage, particularly when

forced to face life and its issues alone. Recovery is powerful and incredible when it happens, but that same power makes it dangerous. Children should never have to face their recovery alone.

In order to defeat the prejudices surrounding addiction and alcoholism, we must begin by addressing the root question of guilt as we perceive it in our society. At first glance young addicts are perceived as the problem, being a curse or a burden to their families. As family dynamics are examined, another culprit is discovered: A parent, generally the father, who has misguided his family into addiction and/or other problems. At this point, guilt or blame shifts from the adolescent to the parent. But ultimately, when the family, or system, is examined, with all of its influences and stressors, it becomes more apparent that there is another driving force behind the behavior. The family itself is discovered to be an addictive environment, or an addictive system, which victimizes individual members. The addict is the symptom of the family illness.

Claudia Black, in her book It Will Never Happen to Me!, details the results of being raised in an alcoholic family.[14] Her intended market is adult children of alcoholics, or ACA'S, who now have their own twelve-step

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[14] Claudia Black, It Will Never Happen to Me! (New York: Ballantine, 1981.)

recovery program. She does not specifically address the alcoholic, as her intention is to demonstrate the difficulty which adult children of alcoholics have in coping with the world. One can easily conclude that the alcoholic is the culprit, the one responsible for the family dynamic, when in reality, it is the family dynamic itself, handed down through the generations and adapted to a changing environment, which is the culprit.

Sara Hines Martin quotes Cathleen Brooks as stating that the "alcoholic is the neediest person emotionally in the family."[15] She is referring to adult alcoholics, and once again, can easily infer that blame lies in the alcoholic. But in order to understand and treat addiction, and ultimately dysfunction, we need to comprehend individual responsibility and systemic guilt. If blame needs to be placed, it needs to be aimed at the dysfunctional family system, while also stressing the importance of individual responsibility for both the existing condition and recovery. But even the family system is the result of other influences such as prior family history and societal pressures.

Healing families ultimately give up the need to point fingers in any direction. They have become aware of how they all worked in concert to create their circumstance while each of them takes responsibility for his or her contribution to the problem, along with the corrective

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[15] Martin, 39.

actions needed. This may sound idealistic, and obviously none of us sees so clearly our position within our family system that we can be perfectly concise about our contribution. But before the healing process of real recovery can take place, the weight of this formula has to be felt by the addict and his family.

Recapturing Parenthood: The Crisis and the Breakthrough

Crisis is endemic to dysfunctional families. Whenever the systems uneasy balance is threatened, the family will tend to initiate a crisis in order to reestablish the former stability. As noted earlier, Wynn describes this as "a clumsy attempt at self styled therapy; and the family seldom recognizes it has that purpose."[16] If the crisis is serious enough, even the closed system of the dysfunctional family will accept some outside intervention. A family which brings one of its children into treatment has taken this step, and has admitted some helplessness at its situation.

This crisis is not enough, though, to push the dysfunctional family into the realization that it is a sick system. Parents generally maintain a guarded posture, presenting themselves as benevolent and caring for bringing the child to treatment. But, as crisis has been instrumental in taking this first correcting step, it can also be part of the continuing process if the family is convinced to participate in treatment. Even treatment teams

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[16] Wynn, 27.

which are not adept at focusing crisis and strife in a therapeutic setting may find crisis contributing to a positive change if the family is kept in treatment.

John Wynn insists that the family must be viewed as the patient.[17] He indicates that therapists have often found that they brought about improvement in individual patients only to be "totally defeated by the family's power over the patient."[18] In a treatment or therapeutic setting, according to Wynn, families have three basic characteristics in common: Homeostasis, the identified patient, and the double bind. Homeostasis is that uneasy balance mentioned earlier in Chapter 3; the identified patient is that person in a troubled family who is designated as the problem; and the double bind is the confusing system of communication in dysfunctional households which creates constant uneasiness with conflicting messages.

The double bind is new to the discussion, and needs some elaboration, as it does play a role in creating crisis and also in preserving family silence to outsiders. Double binds are those communications which send two messages: "You had better enjoy yourself"; "Don't lie. . .don't tell your father (or mother) about this"; mothers who insist on doing all the work in the kitchen and then complain about their work never being done; and fathers who complain that their

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[17] Wynn, 31.

[18] Wynn, 31.

children are lazy, and then criticize them for botching the lawn mowing job. Other forms of double bind exist, and everyone has been subjected to them at some time. In treatment they may occur when children hesitate to criticize their parents, feeling indebted to them instead.

Crises occur as anxiety builds over an increasingly intolerable circumstances or in anticipation of some difficult disclosure or revelation. Most instances of healthy transition in family recovery will include a crisis: either the addict will begin acting out, the parents or another family member will become balky or resistant, or some unforeseen emergency will be precipitated. But as the family is drawn through the crisis in a healthy manner, the dread of negative expectations will be met with less than the anticipated results. What we have, then, with a family in treatment is a crisis-creating family which is once again in crisis. But the anxiety surrounding the crisis will hopefully be directed toward disclosure or revelation, or the opening up of a formerly closed family system to therapeutic or healing intervention.

The closed family is the most severely dysfunctional system, creates the greatest crises, resists intervention the most, and yet can avail itself of crisis in treatment the most.[19] Crisis is part of its internal language, and it provides familiar territory in treatment. The fear of

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[19] Martin, 47.

treatment and its revelations can obviously be stifling, particularly to a family unaccustomed to outside lookers, yet crisis can provide a familiar tension which the family members know from experience.

Parents fear the results of crisis the most, while children tend to see it more hopefully. To the parent a crisis can threaten his or her parenthood, position in the community, and irrational or weak self-esteem. Crisis threatens the parental role. If parents can experience crisis and resultant healing in treatment, they may slowly move back into the more appropriate roles they abandoned or never assumed. Parenthood, and consequently the family, can be recaptured.

The vision of family health presented at the beginning of the chapter indicated that healthy family systems displayed characteristics of openness and encouragement of individual development, or individuation. The initial crisis of treatment is the first opportunity many families have had to experience openness and to share their issues with the outside world. This experience can also produce individual growth among all family members if treatment is approached from a family perspective. Throughout treatment, each crisis can be viewed as an opportunity for positive growth in both of these characteristic areas. But these beginnings of openness and individuation must continue to be encouraged if family members, and particularly children, are

to begin experiencing that sense of self-worth and lovableness as individuals which is central to healthy families.

CHAPTER 5

Reestablishing the Family: The Model for Recovery

Treatment is treatment, and recovery is recovery. Treatment may or may not be effective, whether inpatient or outpatient, whether tended by a brilliant psychiatric/ psychological staff or not. Treatment is simply treatment, much like applying disinfectant to the wound. If the individual does not guard against reinjury or infection, the wound will not heal. Individuals and families must decide to recover in order for treatment to become recovery. In addition, recovery lasts well beyond treatment, and possibly a lifetime. Recovery is the direct result of commitment, and in this case, family recovery is the result of family commitment.

The purpose for this project is not to redesign any current treatment programs. It is intended, though, to offer an alternative philosophy which places the concept of family, or system, recovery at the front of long term treatment issues. Treatment programs need to perform their work on individual addicts and alcoholics, and they often need to isolate and stabilize individuals due to the severity of their condition. But they need to draw the

family into the process as much as possible, with the understanding that the family is the most powerful influence on both the individual's existing condition and future recovery.

The philosophy that addiction is a symptomatic condition of dysfunctional family living suggests a recovery ideal which extends through treatment and into the future, offering the family a stable base from which to effect its own recovery.[1]

This chapter explores two different treatment formats that attempt to engage the family in the recovery process. These two examples differ from one another in their style, but both draw the family into their formulas. A third example, which is a model for family programs rather than a treatment format, is also reviewed. This model is a family recovery platform which supports healthy, sober activities for families, and is adaptable to a wide range of primary treatment formats. It is also adaptable to a wide range of environments, including churches, that desire to address addiction and provide ministry with understanding and sensitivity.

Treatment Models

Although, as already stated, the purpose here is not to establish a new treatment model, it is important to have a

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[1] Martin, 28.

basic understanding of what occurs in treatment. In this section two different treatment strategies are outlined, addressing the two major areas of the recovery process, primary treatment and long term recovery. The first is the Anchor Recovery Program operating out of Anchor Hospital in Atlanta, Georgia. The second is an adaptation of Terence Gorski's developmental model of recovery and relapse by Pamela Clapp, M.A. Each has its successes, and they both support the critical area of family involvement. The next section describes the P.A.R.T.S. (Parents and Adolescents Recovering Together Successfully) program, which developed out of the REACH recovery program of Harborview Hospital in San Diego, California.

An important element in any discussion and evaluation of treatment programs is the consideration of inpatient vs. outpatient treatment. Some programs are purely inpatient, while others are purely outpatient and tend to be community sponsored. Others combine inpatient and outpatient schemes, with individual cases being assigned a different track by an intake team. This method is being encouraged by insurance and government funding agencies. Where the average length of inpatient treatment in recent years was six weeks, it is now approaching two weeks, followed up by outpatient monitoring. Whether this will prove to be effective is yet to be seen. New "fast tracks" are still

developing.[2]

The Anchor program states in its purpose, "It is our intention to provide a well-rounded, holistic, flexible approach to treating adolescents."[3] The program includes a total of thirteen separate modalities, or treatment procedures, including:

1. twelve step self-help groups
2. chemical dependency education
3. chemical dependence process groups
4. skills groups
5. therapy groups
6. topic groups
7. progress groups
8. community meetings
9. leisure/recreactional therapy
10. school
11. family programs
12. relapse prevention track
13. continuing care[4]

Anchor has a variety of staff members including psychiatrists, clinical psychologists, certified addiction counselors, family therapists, social workers, psychiatric nurses, teachers, and physical education specialists. This

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[2] Hearn, 39.

[3] Morrison et al., 48.

[4] Morrison et al., 48-49.

is not a cheap program to manage, but it does address all possible areas of treatment concern.

Each modality does not necessarily require a separate staff person, and some modal formats occur automatically in the treatment setting, such as progress groups and topic groups. Treatment groups are the primary context, and are extremely effective in establishing peer group recognition and peer support. Although the Anchor program looks weighty due to planning and activity requirements, merely utilizing many modalities does not mean that a particular program is overburdened. But the treatment process can become bogged down in the tracking and individual evaluation.

Family programs are handled here as a separate modality. According to Morrison et al., family members are required to participate in group sessions throughout all levels of care.[5] This includes multifamily groups, in-house twelve-step programs twice weekly and on weekends during the inpatient phase, spiritual groups, self-help group meetings, and leisure and skill groups. The family programs definitely address the need for family involvement.

In addition to the continuing care feature of this program, another element that is particularly notable is the relapse prevention track. It approaches relapse as a critical stage in the process of recovery, and not as

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[5] Morrison et al., 50.

treatment failure. One phrase commonly spoken in the recovery business is that "relapse is part of recovery." Even AA literature approaches relapse as an individual's own search for the reality of his condition.[6]

Relapses are going to occur in a large number of cases, and should not be considered failure. An addict will tend to seek out his old ways of coping when stress levels increase, despite his knowledge of a better way. An addictive family system will also encourage this as it tends to seek its old level of dysfunction. Along the way notable signs will appear, signalling impending relapse. These are called "warning signs" or "red flags."[7] As individuals learn to recognize relapse behavior and develop an appropriate plan to deal with it, they will ultimately move out the danger zone which many seem to operate in perpetually. In developing a relapse prevention track, Anchor has utilized Gorski's model of relapse prevention.[8] That model treats relapse as a part of recovery and avoids the characterizations of failure and setback.

One concern regarding a program like this is the difficulty of management within a limited economic framework. Multimode programs have developed out of the old

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[6] Alcoholics Anonymous World Services, Aocoholics Anonymous, 3rd ed. (New York: AA World Services, 1976), 418-438.

[7] Morrison et al., 50.

[8] Morrison et al., 50.

single focus camp-style recovery programs of the sixties and seventies, which sent recovering addicts home on a spiritual high but without essential tools to cope with the stresses of their former environments. Education and directed group process are essential to successful treatment and recovery. But any truly successful program must have a narrow over-arching philosophy which is flexible enough to withstand increasing pressure from the economic providers. Multimode programs can lose sight of their philosophy when overburdened with tracking individual success within each modality.

A strong point to this program is that it insists on family involvement in the treatment process. Family involvement is not limited to one modality either. Rather, the program stresses activities which encourage families to reach outside their protective envelope, which had restricted them from healthy, open interaction with the external environment. Family members are encouraged to seek methods of individual growth and enrichment, including education, recreation, and artistic development.

The second example of a treatment format is Pamela Clapp's adaptation of Gorski's developmental model of recovery and relapse. At the outset she stresses that possibly the most important factor for success in adolescent recovery, aside from individual commitment, is family

involvement.[9] She indicates a concern for the adolescent left alone to reenter his of her old environment, lacking both life skills and maturity to overcome the obstacles.

The discussion in Chapter 3 identified dysfunctional, or addictive, families as secretive and closed systems. Pamela Clapp reinforces this:

> When an adolescent and his family enters a treatment facility for the first time, they have usually exhausted all personal options for solving the problem: At their wits end, the family and the adolescent have been unsuccessfully attempting to rectify the situation behind closed doors. Instead of solving the problem, though, most likely they have complicated it through secrecy, isolation, poor problem identification, and a resulting increase in family stress and fatigue.[10]

In adapting Gorski's model, she identifies this as the pretreatment phase, "characterized by the collapse of denial on the part of the adolescent and the family."[11]

Whereas the Anchor program defines itself in terms of modalities, the Gorski model is defined in phases of recovery, marked by certain milestones which the recovering addict or alcoholic should reach. Within each of these phases are certain elemental treatment needs which should be addressed and met. These six phases are identified as:

1. Pretreatment
2. Stabilization
3. Early Recovery

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[9] Clapp, 27.

[10] Clapp, 27.

[11] Clapp, 27.

4. Middle Recovery
5. Late Recovery
6. Maintenance[12]

In the pretreatment phase an obvious milestone is the recognition of substance abuse as the primary focus. This is essential, for if the purpose of treatment is confused by a variety of issues such as emotional or psychiatric problems, school problems, or behavioral problems, then the issue of substance abuse, or addiction, loses its emphasis. When chemical dependency is a factor in a child's behavior it is the primary problem which must be addressed. Other difficulties can be dealt with more effectively in subsequent phases.

This model takes into account the development, or unfolding, of personal and family issues as an individual passes through the phases of recovery. In the second phase, the stabilization phase, the adolescent and his family will typically be involved together in treatment planning. During this period, according to Clapp, family problems may surface which need to be addressed. She further contends that, whether or not family problems are identified, family members need to become aware of the fact that the patient's recovery relies heavily on family growth and development.[13]

This model approaches the recovery process as being quite long, with the middle recovery phase beginning after

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[12] Clapp, 27-28.

[13] Clapp, 28.

the individual has been active in recovery for one and a half to two years: Not until this time can core family issues be correctly addressed: "According to Gorski, deeply rooted childhood problems should be faced only when the recovering alcoholic is solid enough in his or her sobriety to handle the considerable emotional pain these issues can raise."[14]

The recovery phase, according to this model, is where childhood losses, hurts, and traumas can be allowed to surface and be dealt with. If the family has been guided through its own recovery process, then its members can participate in sharing and healing the old wounds without threatening crisis or destabilization.[15]

The entire process of recovery from this perspective is based on the recognition of the importance of an individual's family being available to address each issue as it comes up in its own appropriate time. Although the focus of this model is the individual, the treatment format provides a basis for family recovery which is equally as valid as the individual's. Additionally, if the family follows through on the process of its own recovery, the addict is much more likely to be drawn through particularly sticky stages where he might otherwise face relapse or setback.

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[14] Clapp, 30.

[15] Clapp, 31.

The time frames allocated for transition through the various phases seem quite long at first, but they accurately allow for the time it takes most individuals to move through the process. In addition, it is important to consider that crisis is endemic to dysfunctional families, and can be used as a tool in recovery. Therefore it should not be avoided or diffused unless a definite danger is present. Crises have their risks, but should be considered opportunities also.

THE P.A.R.T.S. MODEL

The remainder of this chapter discusses a program which was developed by a handful of parents who recognized a need to participate in their children's recovery from addiction. P.A.R.T.S., or Parents and Adolescents Recovering Together Successfully, came into being almost by accident. In the early 1980s, parents of adolescents in treatment at the REACH recovery program at Harborview Hospital in San Diego were being introduced to a relatively new prototype of treatment. They were being asked to participate in the treatment and recovery of their children in more than just a financial manner. The REACH program, as many others, was developing family oriented modalities which consisted of more than just family therapy. Families were participating with other families in large group settings, and parents were participating in their own groups with other parents. Although specific goals and milestones were not part of the

agenda, parents began seeing the value of their participation, not only for the patient, but also for themselves. As an unexpected result, parents began feeling good about being parents, despite their sense of past failure.

At the time, this was new territory. The ordinary mode of support for family members, or codependents, was Alanon. Alanon has long been an adjunct to Alcoholics Anonymous, but did not draw large numbers from the segment of the public with chemically dependent children. It generally supported family members of adult alcoholics. The impact of Alanon has been felt, however, because it extended the twelve-step concept of recovery to other family members, and not just to alcoholics and addicts. Family members, particularly spouses, were given their own priority in recovery through Alanon.[16]

Alanon, though, actuated the concept of providing support and resources to family members, primarily spouses, of addicts and alcoholics. Today, Alanon still maintains that focus, and it is a valuable resource for family members. But the addicted member, although participating in individual recovery, may not be participating in family recovery. The unique contribution of the REACH treatment program and the P.A.R.T.S. ideal is that, in their

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[16] Kellerman, 11.

formation, they encouraged participation of the entire family, and they stressed the need for families to address their own addictive character. The REACH treatment program has since ceased to operate, as the result of budget constraints brought on by insurance industry restrictions, but P.A.R.T.S. has continued on, and provides support to treatment programs at several other San Diego area hospitals.

As the REACH program developed, family groups began meeting in an aftercare format. In other words, after primary treatment ended, the patients and their families continued in a twice weekly program. Today, as already discussed, we see almost all programs stressing such close family involvement from the beginning of treatment. Ten years ago it simply seemed to be a good idea. The two models presented earlier demonstrate how far the idea has come. Terence Gorski began stressing his family oriented recovery ideals in the mid-80s, and programs like Anchor have developed in the recent past.[17]

REACH aftercare also emerged as an outgrowth of this process. One unique option of REACH aftercare was that patients and families were allowed to continue participation indefinitely. Ordinarily, participation in the after treatment phase of most programs is limited to a maximum of six months, and often as short as six weeks. During the

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[17] Morrison et al., 53.

developmental period of family programs, parents did not feel encouraged to participate. Thus, they generally lost interest soon after their teenager was discharged from treatment, and ultimately dropped out of the picture. Their value in treatment and recovery was not recognized as fully as it is today. Yet even now, with drastically increased emphasis on parental and family participation, and with family recovery understood as a separate treatment issue, family members will still fade out of the picture quickly if allowed.

A few of the parents who participated in REACH aftercare recognized that they needed and wanted further involvement in healthy, or "sober," activities with their children. They recognized their tendencies to isolate and keep their problems to themselves, a feature of closed family systems, and they saw areas such as family recreational activities as opportunities to reach outward. They saw that a less therapeutic setting might allow for more open interaction. At this point, parents organized themselves for the purpose of planning activities which protected recovery goals. Parents also organized healthy functions for themselves apart from their children.

This loosely organized group eventually became P.A.R.T.S., and was alloted space and time within the hospital to plan activities. The recovery program staff recognized the value of this structure, and saw its

application in other areas. As parents grew in their recovery they became valuable as a resource to new parents, and a loose form of sponsorship developed. Parents with experience in family recovery encouraged and assisted other families in their process. The hospital and P.A.R.T.S. worked closely together, and the treatment staff began organizing aftercare around the core parent group. As they grew together they developed the following features:

1. Twice weekly meetings, one weeknight and one Saturday morning.

2. The weeknight meeting consists of two one-hour segments, with the first seqment being plenary groups for adults and adolescents separately. Another plenary group is provided for siblings. The second half of the week night meeting is established on a monthly schedule and features a varying format including multi-family groups, stag groups, speaker groups, and a monthly recovery birthday celebration.

3. The Saturday meeting allows patients and former patients to meet in planning and plenary groups. The parents meet in a planning group for the purpose of keeping a full calendar of planned outside sober activities including picnics, camping, recreational outings, parent dinners, etc. The second half of the parent meeting allows time for interacting with treatment staff.

4. As an organization, P.A.R.T.S. takes no stand on any particular treatment program or modality. It exists as an adjunct to treatment.

5. P.A.R.T.S., by virtue of its by-laws, "is an organization that was formed to help families work and play together in sobriety. We hope to learn from each other, and help each other along life's path. Our common goal is sobriety and to reconstruct the family unit that has been strained by our previous experiences. The main rule we have is no drugs or alcohol allowed at any of our events or functions."[18]

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[18] P.A.R.T.S., By-laws, San Diego, 1987, 1.

Over the last two years the P.A.R.T.S. format has been adopted by four other hospital-based treatment programs in the San Diego area, and parents from all groups meet together for the planning of joint activities. The value of the program is that it functions as a support to recovery in a similar fashion to Alcoholics Anonymous, and it dictates no specific treatment plan or modality. Many of the parents are recovering from alcoholism or addiction themselves, and they can offer valuable input into the long-term needs of recovery.

The simplicity of the P.A.R.T.S. format makes it extremely adaptable, and it does not necessarily need a treatment program to operate within. It provides a scheduled format of group meetings and activities which allow entire families and individual members to meet for the purposes of recovery and sober recreation. The treatment programs which utilize the format generally provide space for group sessions and business meetings, and they adopt an aftercare ideal which allows for indefinite participation by both patients and family members. The San Diego treatment programs which have adopted the format maintain identical aftercare schedules in order to allow for continuity in planning activities. When a new group is established, families which are experienced with the P.A.R.T.S. program may alternate to that group as a resource and an encouragement to families and staff which are new to the

format.

In the long run, healing families provide one of the best supports and resources for the recovery of other families. Alcoholics Anonymous has operated on that same principal with regard to individuals, and it is simply the most useful resource that is available to the treatment community. No treatment program operates without stressing the need for an A.A.-based long term plan. In much the same way, P.A.R.T.S. is an organization of parents with family recovery as its goal.

Reiterating what was said at the beginning of this chapter, treatment is treatment, and recovery is recovery. Recovery occurs as the result of long term commitment, and includes elements of growth and improvement beyond the idea of simple abstinence from chemicals. Family recovery, likewise, is the result of family commitment, and it can provide the most stable base from which to insure individual recovery. The P.A.R.T.S. program embraces this philosophy of family recovery, and provides modeling for families that are new to treatment and recovery.

At a time when external forces, such as the insurance industry and the government, are influencing a potential degradation of treatment services, community-based programs such as P.A.R.T.S. must be considered as potential standard-bearers for adolescent recovery. Although P.A.R.T.S. is not a professional organization, and is supported solely by

member contributions, it carries the seeds of the latest advances in recovery research.

In keeping with the ideals of Alcoholics Anonymous and Alanon, P.A.R.T.S. views recovery as a lifetime commitment, and has been structured with that long-term goal in mind. It has already proven to be a valuable tool to the treatment industry in the San Diego area, and could prove to be the foundation for new community-based recovery programs.

CHAPTER 6

Summary and Conclusions

Chapter 1 indicates that the goal of this project is toward the successful treatment and recovery of adolescent addicts. In order to accomplish this successfully, the proposal is made that the family be targeted as the primary context within which to address recovery. At the present, treatment programs stress the importance of drawing the family into an individual's treatment and recovery, but they stop short of managing family involvement on a large scale.

For over a decade, specialists have been addressing the need to treat the family as a system harboring alcoholism and addiction as a symptomatic response to family illness. A 1976 publication by Joseph Kellerman declared "The primary focus in alcoholism [and addiction] should be on the family."[1] Stanton and Todd, in 1984, stressed the need to treat the family as an addictive unit, although only one member may be the identified patient.[2] The natural conclusion, then, is that treating the illness in the family would offer the greatest hope for the recovery and wellness

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[1] Kellerman, 5.

[2] Stanton and Todd, 22.

of individual members. Yet society has continued to respond to addiction with an individualistic attitude, shaping treatment profiles heavily in favor of individual treatment. Although family recovery is stressed, treatment specialists still find themselves treating individuals while their families stand in the shadows.

Chapter 2 addresses the general condition of the treatment industry today, including the public perspective that influences financial support for treatment, and the tension between the ideals and goals of chemical dependency treatment and the sources of that financial support. This tension is interpreted as pressure from the insurance industry and the federal government to reduce costs and meet difficult goals for treatment. The interview with Herbert Kleber, Deputy Director for demand reduction at the Office of National Drug Control Policy, suggests the possibility of an immense new infrastructure for monitoring treatment of chemical dependency.[3] The impact of this agency could produce a reduction of the quality of treatment as well as threaten development of new treatment profiles and modalities.

If restrictions and controls, intervening agencies, and financial cutbacks become the controlling factor, and if, as Wynn suggests, the federal government's movement toward a national family policy results in a "terribly restrictive"

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[3] See Kramer, 54.

environment, we may experience many losses in family programs.[4]

Chapter 2 also deals with the current posture of the treatment industry toward an ideal of family recovery. Although it has been stressed and demonstrated that individual recovery is enhanced by, and sometimes requires, the parallel recovery of the family, treatment programs still fall terribly short of that ideal. This does not mean that these programs fail, but they certainly suffer when counting recovery successes.

Regarding adolescent recovery, Pamela Clapp indicates that family support and involvement in the recovery process is absolutely essential to the recovery of the individual: "Without that support, the adolescent is left alone to face nearly insurmountable obstacles."[5]

Chapter 3 develops a systemic approach to addiction, presenting the family as an interdependent system, and the addictive family as a dysfunctional interdependent system. The purpose of this presentation is to move thinking from moral issues and individual guilt toward an understanding of the multigenerational effect of dysfunction and addiction. The dysfunctional family is described as one in which there is a confusion of roles, a general lack of self-affirming responses among family members, and the lack of a sense of

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[4]Wynn, 12.

[5] Clapp, 27.

self-worth among individual members.

Several case studies demonstrate the concept that addicted children are the presenting symptom of sick or dysfunctional family systems. The further failure of these families to support or participate in the recovery of their children resulted in difficult recoveries which were marked by relapse and failure in interpersonal relationships.

Dysfunctional families tend to become closed to the outside world, and demonstrate resistance to change. John Wynn describes this as homeostasis, or the uneasy balance which the family system attempts to maintain.[6] If the system senses a threat, the family will act in some fashion in order to protect itself. This response is generally a crisis which signals the family to regroup and close itself even further from outside intrusion.

The research indicates that possibly the most important issue for children raised in dysfunctional addictive homes is that of abandonment. Sara Martin asserts that the basic issues for these children are abandonment and rejection,[7] and Stanton and Todd note an underlying fear of separation, or abandonment, from the outset of their research.[8]

Chapter 4 demonstrates a concept of family recovery which utilizes some of the features of dysfunction itself,

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[6] Wynn, 27.

[7] Martin, 36.

[8] Stanton and Todd, 12.

particularly the cycle of crisis and return to stability. Dysfunctional families tend to generate crisis whenever the static condition of the system is threatened, which occurs frequently as a part of the cycle. The crisis itself is the sign for the family to regroup, but occasionally the crisis is too large for the family to cope with. In the case of an addicted child, treatment is ultimately sought, and is sometimes the only instance of the family opening up to outside intervention. In other words, the crisis has generated a potentially healthy response. If family members, and particularly parents, receive affirmation as a result of their decision, then other healthy responses may follow.

Chapter 4 also presents a vision of family health which has as its end product the generation of a sense of self-worth and lovableness from individual members. The research of Chapter 3 indicated that children raised in healthy homes have a strong sense of their own intrinsic self-worth. The most apparent features of families which promote this well-being are those of openness and individual growth, or individuation of family members. In addition, roles in healthy families are well defined and protected.

The problem still remains how to move from unhealth to health, which is the ultimate and most sought after goal of all treatment programs. There is no new formula or discovery which this project proposes, but the research

highlights existing conclusions and propositions, suggesting that the most powerful key to recovery is already in our hands. This key is the family, and we simply fail to utilize it as necessary. The general attitude of those who influence treatment, including government and the insurance industry, is still toward treating the individual, with little consideration of the impact on the family, or the needs of the family for treatment and recovery.

Chapter 5 is a review of two approaches to treatment which include families in the entire process of treatment and recovery. Both approaches consider the systemic nature of addiction, and conclude that families must be involved in the process from the beginning. The Anchor Hospital program was developed as a multi-mode format which approaches treatment from the notion that it should impact all areas of an addict's life. The family is drawn into this format because it is seen as essential to individual recovery.[9]

Pamela Clapp's model is based on Terence Gorski's concept of relapse and recovery as a developmental process. She suggests six phases of the recovery cycle, with milestones which mark the developmental process through the phases. As in the Anchor model, she insists that family involvement in the recovery process is essential to individual recovery.[10]

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[9] Morrison et al., 48.

[10] Clapp, 27.

Chapter 5 concludes with an examination of the P.A.R.T.S. program, which is a parent developed plan for family involvement. The purpose of the program is to facilitate long term family-oriented recovery which is independent of any professional treatment format. P.A.R.T.S. does not support or oppose any particular treatment program, but is intended to promote and develop the concept of family recovery. It draws from the A.A. concept of a life-long commitment to recovery, and is based on the belief that the family is the foundation of recovery.

Restatement of Problem and Thesis in Light of Findings

The opening statement of this project indicated that the purpose was to address the need for family involvement in the recovery process of adolescent addicts. The problem stated was: "While the concept of family involvement in the treatment and recovery of chemically dependent children is considered to be essential to their success, few treatment programs effectively incorporate families into that process.

Research and findings indicate that adolescent chemical dependency treatment, in general, simply does not draw the family into the process. Although the need is recognized and supported by the preponderance of evidence, the treatment industry is structured and supported in a manner which dictates an individual focus. The research in this project intensifies the statement of the problem with which it began. It demonstrates the need for complete family

involvement in the recovery process, based on a systemic perspective of addiction and recovery. In other words, family dynamics are the most powerful influence in addiction, and are likewise the most powerful influence in recovery. Individual recovery from addiction, particularly that of an adolescent, will stand the greatest chances of success if the family participates in the process of its own recovery.

The original thesis statement reads: "The intent of this project is to demonstrate that an organized treatment program, which includes close family participation in both the recovery process of the individual and in its own recovery as a functional whole, is essential in the recovery of chemically dependent adolescents." The weight of evidence indicates that this, in fact, is true. But the research also seems to indicate that family recovery should possibly be the primary focus of treatment, as it then provides an appropriate environment within which individual recovery can occur.

A restatement of the thesis, therefore, should read: Family recovery provides the most ideal environment within which to accomplish the individual recovery of chemically dependent adolescents. Any use of this proposition, though, should take into account that the family recovery process involves its own recovery as a dysfunctional and addictive environment. The family is an environment in which

addiction develops, and should be treated as the primary source of individual addictive behavior.

Conclusions

The product of this project is the suggestion of an alternative philosophy for addiction treatment which places the concept of family recovery at the front of long term recovery issues. The P.A.R.T.S. program, suggested partially because of its adaptability to a wide range of treatment formats, is relatively small and confined to one region. It formed as a grass roots response to the needs of concerned parents. Obviously, the parents who conceived the program were willing to participate in the recovery of their child. They did not fit into the general scheme of dysfunctional families in that they were willing to change, at least in part. They discovered in the process of their recovery that many unseen changes would be required, but the program continued.

The fact that P.A.R.T.S. has survived indicates that parents are willing to go through the process despite the threat to their old family balance. This indicates hope that family recovery can be initiated and that it does not always require the goading of leading-edge experts.

The current crisis in the treatment industry, with its resultant cutback of inpatient treatment and threat of severe limitations on the growth and development of family programs, indicates a growing need and opportunity for

community involvement, particularly from churches. Although churches have taken a back seat in addiction recovery, they are still perceived as a stronghold of family ideals within our society, regardless of individual judgements concerning religion or spirituality.

Certain programs and elements of the recovery continuum are extremely adaptable to a church environment, and appear to be waiting for the assistance of a community dedicated to caring and healing. These include family recreational activities, provision for on-going family recovery groups, and an atmosphere that can nurture families which are healing from potentially disastrous wounds. Obviously, not all church communities can support these needs, but there are also many which can.

The P.A.R.T.S. program itself is easily adapted to a church setting, and any church which might consider extending itself into the general community by establishing or adopting a P.A.R.T.S. program would not merely be opening its doors to orphans and outcasts. Many families participating in recovery also lead active religious and spiritual lives. Sponsoring a recovery program for addicts might be frightening at first, considering the public perception of addiction, but it could also be a new opportunity for healing to member families.

The possibilities are very encouraging for churches and pastoral ministry with a special interest in recovery. It

may finally be time for churches to reinvolve themselves with the real issues of our day before the government does. Although this project does not specifically target pastoral ministry as the new environment for addiction recovery, it is a fertile area and needs careful consideration. Our culture is plagued with addiction, and this plague directly impacts the church. No one is immune.

Although the idea of the P.A.R.T.S. program has expanded in the San Diego area, it is certainly not a concept which has been widely adopted in our country. Because of its simplicity and because it is not a treatment modality, it is easily adapted to contexts outside of the clinical setting. Clinical treatment programs may continue to improve or they may become completely restricted, but recovery involves much more than good hospitals. Just as Alcoholics Anonymous has become the foundation of all individual recovery, at the same time maintaining separation from endorsement of a particular treatment style or program, a family-oriented recovery program can ultimately provide the same support to families.

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